MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Road Pasadena, TX 77503	MDR Tracking No.: M4-04-2252-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Company P O Box 13367 Austin, TX 78711-3367 Flahive, Ogden & Latson Austin Commission Representative Box 19	Date of Injury: Employer's Name: AM FM Insurance Carrier's No.: 900000273

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/04/02	**11/11/02**	**Surgical Admission**	**$ 69,881.45**	**$ 0.00**

PART III: REQUESTOR'S POSITION SUMMARY

TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill. See Tex. Admin Code Section 133.401 (c). This figure is presumptively considered to be "air and reasonable" in accordance with the preamble of TWCC Rule 134. See 22 TexReg 6265. Further, the TWCC stated that the stop-loss threshold increases hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers. See Id. At 6279.

The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services, which are not related to the compensable injury. At that time, if the total audited charges for the entire admission are below $40,000, the Carrier may reimburse at a "per diem" rate for the hospital services. However, if the total audited charges for the entire admission are at or above $40,000, the Carrier shall reimburse using the "Stop-Loss Reimbursement Factor" (SLRF). The SLRF of 75% is applied to the "entire admission."

PART IV: RESPONDENT'S POSITION SUMMARY

This is a medical fee dispute that stems from treatment the claimant received from the Requestor on 11/04/02. The bill, as originally submitted by the Requestor, is in the amount of $194,964.01. The Requestor asserts that it is entitled to reimbursement in the amount of $146,233.01, which is 75% of the original bill. Carrier maintains that this, the stop-loss methodology, is not the proper way to calculate the reimbursement amount in this case.

Medical bills in excess of $40,000 do not automatically qualify for stop-loss reimbursement. Rather, the per diem rate is the default and preferred method of reimbursement that should be employed unless the Hospital justified use of the stop-loss method in a particular case. SOAH Docket No. 453-03-0910.M4. Stop-loss is to be "allowed on a case-by-case basis" if the $40,000 threshold is exceeded. ID.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually

extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was seven days (consisting of 7 days surgical days). Accordingly, the standard per diem amount due for this admission is equal to $ 7,826.00(7 times $1,118); however, the requestor only billed $ 5,005.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals as follows

Implantables $19,308.00
Implantables 1,485.00

Total plus 10% ($20,793.00 + $2,079.30) = $22,872.30
The carrier has reimbursed the provider for $27,398.80

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

		03-03-05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____